107TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
107–184

PROVIDING FOR CONSIDERATION OF H.R. 2563, BIPARTISAN PATIENT PROTECTION ACT

AUGUST 2 (legislative day, AUGUST 1), 2001.—Referred to the House Calendar and ordered to be printed

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Mr. GOSS, from the Committee on Rules, submitted the following

REPORT

[To accompany H. Res. 219]

The Committee on Rules, having had under consideration House Resolution 219, by a record vote of 7 to 3, report the same to the House with the recommendation that the resolution be adopted.

SUMMARY OF PROVISIONS OF THE RESOLUTION

The resolution provides for consideration of H.R. 2563, the Bipartisan Patient Protection Act, under a structured rule. The rule provides two hours of general debate equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce, the Committee on Ways and Means and the Committee on Education and the Workforce. The rule waives all points of order against consideration of the bill.

The rule makes in order only the amendments printed in the Rules Committee report accompanying the resolution, which may be offered only in the order printed in the report, may be offered only by a Member designated in the report, shall be considered as read, shall be debatable for the time specified in the report equally divided and controlled by the proponent and an opponent, shall not be subject to amendment, and shall not be subject to a demand for division of the question in the House or in the Committee of the Whole. The rule waives all points of order against the amendments printed in the report.

Finally, the rule provides one motion to recommit with or without instructions.

COMMITTEE VOTES

Pursuant to clause 3(b) of House rule XIII the results of each record vote on an amendment or motion to report, together with the names of those voting for and against, are printed below:

89–008

Rules Committee record vote No. 40

Date: August 1, 2001.
Measure: H.R. 2563.
Motion By: Mr. Frost.
Summary of Motion: To make in order the amendment in the nature of a substitute by Representatives Ganske and Dingell which is identical to H.R. 2563, but adds Title VIII, which fully offsets the bill with non-Medicare and non-Social Security surplus dollars by clarifying the customs user fees will be extended through 2011 rather than 2006. Also makes a series of changes to the tax code to reduce fraudulent tax shelters by clarifying and slightly strengthening the economic substance doctrine, modifying penalty provisions in circumstances involving tax avoidance strategies that have no economic substance, and halting the importation of foreign losses.
Results: Defeated 3 to 6.
Vote by Member: Goss—nay; Linder—nay; Pryce—nay; Hastings (WA)—nay; Myrick—nay; Frost—yea; Hall—yea; Hastings (FL)—yea; Dreier—nay.

Rules Committee record vote No. 41

Date: August 1, 2001.
Measure: H.R. 2563.
Motion By: Mr. Goss.
Summary of Motion: To report the resolution.
Results: Agreed to 7 to 3.
Vote by Member: Goss—yea; Linder—yea; Pryce—yea; Hastings (WA)—yea; Myrick—yea; Sessions—yea; Frost—nay; Hall—nay; Hastings (FL)—nay; Dreier—yea.

SUMMARY OF AMENDMENTS MADE IN ORDER UNDER THE RULE

(Summaries derived from information provided by sponsors.)
Thomas/Lipinski/Fletcher/Phelps/Johnson, Sam/Dooley/Cooksey/Lucas (KY)/Hunter: Adds Association Health Plans to the bill and strikes section 511 (Limitations on Number of Medical Savings Accounts (MSAs)), replacing it with fully expanded MSAs. (40 minutes)
Norwood: Provides patient protections and the right to independent medical review for denials of medical care by the health plan; guarantees patients new federal remedies to hold their health plans accountable when they have been injured by wrongful denial or delay of medical care; allows cases against employers to be removed to federal court by the defendant; allows cases against health insurers to be heard in state court; allows employers to designate decision makers who will have sole liability for benefit determinations; ensures that patients must exhaust the independent medical review process before seeking expanded damages in court; allows patients to seek injunctive relief at any time for irreparable harm; allows unlimited economic damages in both federal and state court; limits non-economic damages at $1.5 million; provides that punitive damages will be capped at $1.5 million and will be available only where the designated decision maker fails to comply with the independent medical reviewer's decision that the claim for benefits should be granted; and limits class action lawsuits under

ERISA and RICO to participants in a group health plan established by a single plan sponsor. (60 minutes)

Thomas/Cox/Sensenbrenner/Tauzin/Boehner: Reforms the medical malpractice laws for health care providers to place time limits on lawsuits, cap damages, establish the collateral source rule, provide for several liability, and protect against lawsuits for products that meet FDA standards. Grandfathers existing laws and allows future state laws to supercede federal standards. (40 minutes)

Text of Amendments made in order under the rule:

1. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE THOMAS OF CALIFORNIA, OR REPRESENTATIVE LIPINSKI OF ILLINOIS, OR A DESIGNEE, DEBATABLE FOR 40 MINUTES

Insert before section 401 the following heading (and conform the table of contents accordingly):

Subtitle A—General Provisions

In section 301(a), insert "subtitle A of" before "title IV".

Add at the end of title IV the following new subtitle (and conform the table of contents accordingly):

Subtitle B—Association Health Plans

SEC. 421. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"SEC. 801. ASSOCIATION HEALTH PLANS.

"(a) IN GENERAL.—For purposes of this part, the term 'association health plan' means a group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

"(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

"(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care;

"(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership in the sponsor; and

"(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), and (3) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

"(a) IN GENERAL.—The applicable authority shall prescribe by regulation, through negotiated rulemaking, a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

"(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), in the case of an association health plan that provides at least one benefit option which does not consist of health insurance coverage, the applicable authority shall certify such plan as meeting the requirements of this part only if the applicable authority is satisfied that the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

"(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

"(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation, through negotiated rulemaking, for continued certification of association health plans under this part.

"(e) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

"(f) CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—An association health plan which offers one or more benefit options which do not consist of health insurance coverage may be certified under this part only if such plan consists of any of the following:

"(1) a plan which offered such coverage on the date of the enactment of the Bipartisan Patient Protection Act,

"(2) a plan under which the sponsor does not restrict membership to one or more trades and businesses or industries and whose eligible participating employers represent a broad cross-section of trades and businesses or industries, or

"(3) a plan whose eligible participating employers represent one or more trades or businesses, or one or more industries, consisting of any of the following: agriculture; equipment and automobile dealerships; barbering and cosmetology; certified

public accounting practices; child care; construction; dance, theatrical and orchestra productions; disinfecting and pest control; financial services; fishing; foodservice establishments; hospitals; labor organizations; logging; manufacturing (metals); mining; medical and dental practices; medical laboratories; professional consulting services; sanitary services; transportation (local and freight); warehousing; wholesaling/distributing; or any other trade or business or industry which has been indicated as having average or above-average risk or health claims experience by reason of State rate filings, denials of coverage, proposed premium rate levels, or other means demonstrated by such plan in accordance with regulations which the Secretary shall prescribe through negotiated rulemaking.

"SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

"(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

"(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

"(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

"(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

"(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

"(B) LIMITATION.—

"(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

"(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

"(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

"(C) CERTAIN PLANS EXCLUDED.—Subparagraph (A) shall not apply to an association health plan which is in existence on the date of the enactment of the Bipartisan Patient Protection Act.

"(D) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

"(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

"(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b); and

"(2) the requirements of section 804(a)(1) shall be deemed met.

The Secretary may by regulation, through negotiated rulemaking, define for purposes of this subsection the terms 'franchiser', 'franchise network', and 'franchisee'.

"(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

"(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

"(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met;

"(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met; and

"(C) the requirements of section 804 shall be deemed met.

"(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

"(A) the plan is a multiemployer plan; or

"(B) the plan is in existence on April 1, 2001, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii).

"(3) CONSTRUCTION.—A group health plan described in paragraph (2) shall only be treated as an association health plan under this part if the sponsor of the plan applies for, and obtains, certification of the plan as an association health plan under this part.

"SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

"(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

"(1) each participating employer must be—

"(A) a member of the sponsor,

"(B) the sponsor, or

"(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met,

except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

"(2) all individuals commencing coverage under the plan after certification under this part must be—

"(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

"(B) the beneficiaries of individuals described in subparagraph (A).

"(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Bipartisan Patient Protection Act, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

"(1) the affiliated member was an affiliated member on the date of certification under this part; or

"(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

"(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

"(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

"(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

"(2) upon request, any employer eligible to participate is furnished information regarding all coverage options available under the plan; and

"(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

"SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

"(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

"(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

"(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A));

"(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)); and

"(C) incorporates the requirements of section 806.

"(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

"(A) The contribution rates for any participating small employer do not vary on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

"(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

"(i) setting contribution rates based on the claims experience of the plan; or

"(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 2791(d)(3) of the Public Health Service Act),

subject to the requirements of section 702(b) relating to contribution rates.

"(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

"(4) MARKETING REQUIREMENTS.—

"(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner comparable to the manner in which such agents are used to distribute health insurance coverage.

"(B) STATE-LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to

licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

"(5) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation through negotiated rulemaking.

"(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Subject to section 514(e), nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except (subject to section 514) in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

"SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

"(1) the benefits under the plan consist solely of health insurance coverage; or

"(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

"(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

"(i) a reserve sufficient for unearned contributions;

"(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

"(iii) a reserve sufficient for any other obligations of the plan; and

"(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

"(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

"(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation, through negotiated rulemaking, provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically

provides for and maintains reserves in excess of the amounts required under subparagraph (A).

"(ii) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary. The applicable authority may by regulation, through negotiated rulemaking, provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

"(iii) The plan shall secure indemnification insurance for any claims which the plan is unable to satisfy by reason of a plan termination.

Any regulations prescribed by the applicable authority pursuant to clause (i) or (ii) of subparagraph (B) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

"(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—In the case of any association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to—

"(1) $500,000, or

"(2) such greater amount (but not greater than $2,000,000) as may be set forth in regulations prescribed by the applicable authority through negotiated rulemaking, based on the level of aggregate and specific excess/stop loss insurance provided with respect to such plan.

"(c) ADDITIONAL REQUIREMENTS.—In the case of any association health plan described in subsection (a)(2), the applicable authority may provide such additional requirements relating to reserves and excess/stop loss insurance as the applicable authority considers appropriate. Such requirements may be provided by regulation, through negotiated rulemaking, with respect to any such plan or any class of such plans.

"(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.—The applicable authority may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

"(e) ALTERNATIVE MEANS OF COMPLIANCE.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section (except subsection (a)(2)(B)(iii)), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The applicable authority may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms

of the plan in the form of assessments of participating employers, security, or other financial arrangement.

"(f) MEASURES TO ENSURE CONTINUED PAYMENT OF BENEFITS BY CERTAIN PLANS IN DISTRESS.—

"(1) PAYMENTS BY CERTAIN PLANS TO ASSOCIATION HEALTH PLAN FUND.—

"(A) IN GENERAL.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under paragraph (2). Payments under this paragraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

"(B) PENALTIES FOR FAILURE TO MAKE PAYMENTS.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which was not timely paid shall be payable by the plan to the Fund.

"(C) CONTINUED DUTY OF THE SECRETARY.—The Secretary shall not cease to carry out the provisions of paragraph (2) on account of the failure of a plan to pay any payment when due.

"(2) PAYMENTS BY SECRETARY TO CONTINUE EXCESS/STOP LOSS INSURANCE COVERAGE AND INDEMNIFICATION INSURANCE COVERAGE FOR CERTAIN PLANS.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be: (A) a failure to take necessary corrective actions under section 809(a) with respect to an association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certifies such determination to the Secretary), the Secretary shall determine the amounts necessary to make payments to an insurer (designated by the Secretary) to maintain in force excess/stop loss insurance coverage or indemnification insurance coverage for such plan, if the Secretary determines that there is a reasonable expectation that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

"(3) ASSOCIATION HEALTH PLAN FUND.—

"(A) IN GENERAL.—There is established on the books of the Treasury a fund to be known as the 'Association Health Plan Fund'. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties received pursuant to paragraph (1)(B);

and earnings on investments of amounts of the Fund under subparagraph (B).

"(B) INVESTMENT.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such amounts as the Secretary determines advisable by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

"(g) EXCESS/STOP LOSS INSURANCE.—For purposes of this section—

"(1) AGGREGATE EXCESS/STOP LOSS INSURANCE.—The term 'aggregate excess/stop loss insurance' means, in connection with an association health plan, a contract—

"(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation through negotiated rulemaking) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

"(B) which is guaranteed renewable; and

"(C) which allows for payment of premiums by any third party on behalf of the insured plan.

"(2) SPECIFIC EXCESS/STOP LOSS INSURANCE.—The term 'specific excess/stop loss insurance' means, in connection with an association health plan, a contract—

"(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation through negotiated rulemaking) provides for payment to the plan with respect to claims under the plan in connection with a covered individual in excess of an amount or amounts specified in such contract in connection with such covered individual;

"(B) which is guaranteed renewable; and

"(C) which allows for payment of premiums by any third party on behalf of the insured plan.

"(h) INDEMNIFICATION INSURANCE.—For purposes of this section, the term 'indemnification insurance' means, in connection with an association health plan, a contract—

"(1) under which an insurer (meeting such minimum standards as the applicable authority may prescribe through negotiated rulemaking) provides for payment to the plan with respect to claims under the plan which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination);

"(2) which is guaranteed renewable and noncancellable for any reason (except as the applicable authority may prescribe by regulation through negotiated rulemaking); and

"(3) which allows for payment of premiums by any third party on behalf of the insured plan.

"(i) RESERVES.—For purposes of this section, the term 'reserves' means, in connection with an association health plan, plan assets which meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe through negotiated rulemaking.

"(j) SOLVENCY STANDARDS WORKING GROUP.—

"(1) IN GENERAL.—Within 90 days after the date of the enactment of the Bipartisan Patient Protection Act, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

"(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

"(A) a representative of the National Association of Insurance Commissioners;

"(B) a representative of the American Academy of Actuaries;

"(C) a representative of the State governments, or their interests;

"(D) a representative of existing self-insured arrangements, or their interests;

"(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

"(F) a representative of multiemployer plans that are group health plans, or their interests.

"SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

"(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

"(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority through negotiated rulemaking, at least the following information:

"(1) IDENTIFYING INFORMATION.—The names and addresses of—

"(A) the sponsor; and

"(B) the members of the board of trustees of the plan.

"(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

"(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

"(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

"(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

"(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

"(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe through negotiated rulemaking.

"(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

"(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.

"(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

"(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation through negotiated rulemaking, as necessary to carry out the purposes of this part.

"(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

"(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted

with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation through negotiated rulemaking. The applicable authority may require by regulation, through negotiated rulemaking, prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

"(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed with the applicable authority not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the applicable authority). The applicable authority may require by regulation through negotiated rulemaking such interim reports as it considers appropriate.

"(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

"(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations; and

"(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

"SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

"Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

"(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

"(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

"(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation through negotiated rulemaking.

"SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

"(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the applicable authority makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the applicable authority (in such form and manner as the applicable authority may prescribe by regulation through negotiated rulemaking) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

"(b) MANDATORY TERMINATION.—In any case in which—

"(1) the applicable authority has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements; and

"(2) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims referred to in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

"SEC. 810. TRUSTEESHIP BY THE SECRETARY OF INSOLVENT ASSOCIATION HEALTH PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

"(a) APPOINTMENT OF SECRETARY AS TRUSTEE FOR INSOLVENT PLANS.—Whenever the Secretary determines that an association health plan which is or has been certified under this part and which is described in section 806(a)(2) will be unable to provide benefits when due or is otherwise in a financially hazardous condition, as shall be defined by the Secretary by regulation through ne-

gotiated rulemaking, the Secretary shall, upon notice to the plan, apply to the appropriate United States district court for appointment of the Secretary as trustee to administer the plan for the duration of the insolvency. The plan may appear as a party and other interested persons may intervene in the proceedings at the discretion of the court. The court shall appoint such Secretary trustee if the court determines that the trusteeship is necessary to protect the interests of the participants and beneficiaries or providers of medical care or to avoid any unreasonable deterioration of the financial condition of the plan. The trusteeship of such Secretary shall continue until the conditions described in the first sentence of this subsection are remedied or the plan is terminated.

"(b) POWERS AS TRUSTEE.—The Secretary, upon appointment as trustee under subsection (a), shall have the power—

"(1) to do any act authorized by the plan, this title, or other applicable provisions of law to be done by the plan administrator or any trustee of the plan;

"(2) to require the transfer of all (or any part) of the assets and records of the plan to the Secretary as trustee;

"(3) to invest any assets of the plan which the Secretary holds in accordance with the provisions of the plan, regulations prescribed by the Secretary through negotiated rulemaking, and applicable provisions of law;

"(4) to require the sponsor, the plan administrator, any participating employer, and any employee organization representing plan participants to furnish any information with respect to the plan which the Secretary as trustee may reasonably need in order to administer the plan;

"(5) to collect for the plan any amounts due the plan and to recover reasonable expenses of the trusteeship;

"(6) to commence, prosecute, or defend on behalf of the plan any suit or proceeding involving the plan;

"(7) to issue, publish, or file such notices, statements, and reports as may be required by the Secretary by regulation through negotiated rulemaking or required by any order of the court;

"(8) to terminate the plan (or provide for its termination in accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

"(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

"(10) to do such other acts as may be necessary to comply with this title or any order of the court and to protect the interests of plan participants and beneficiaries and providers of medical care.

"(c) NOTICE OF APPOINTMENT.—As soon as practicable after the Secretary's appointment as trustee, the Secretary shall give notice of such appointment to—

"(1) the sponsor and plan administrator;

"(2) each participant;

"(3) each participating employer; and

"(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

"(d) ADDITIONAL DUTIES.—Except to the extent inconsistent with the provisions of this title, or as may be otherwise ordered by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 704 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

"(e) OTHER PROCEEDINGS.—An application by the Secretary under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding, or any proceeding to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

"(f) JURISDICTION OF COURT.—

"(1) IN GENERAL.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with the purposes of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of, any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding to enforce a lien against property of the plan or the sponsor or any other suit against the plan or the sponsor.

"(2) VENUE.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is situated. A district court in which such action is brought may issue process with respect to such action in any other judicial district.

"(g) PERSONNEL.—In accordance with regulations which shall be prescribed by the Secretary through negotiated rulemaking, the Secretary shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary's service as trustee under this section.

"SEC. 811. STATE ASSESSMENT AUTHORITY.

"(a) IN GENERAL.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Bipartisan Patient Protection Act.

"(b) CONTRIBUTION TAX.—For purposes of this section, the term 'contribution tax' imposed by a State on an association health plan means any tax imposed by such State if—

"(1) such tax is computed by applying a rate to the amount of premiums or contributions, with respect to individuals cov-

ered under the plan who are residents of such State, which are received by the plan from participating employers located in such State or from such individuals;

"(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

"(3) such tax is otherwise nondiscriminatory; and

"(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care under the plan, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

"SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

"(a) DEFINITIONS.—For purposes of this part—

"(1) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

"(2) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

"(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1).

"(4) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

"(5) APPLICABLE AUTHORITY.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'applicable authority' means, in connection with an association health plan—

"(i) the State recognized pursuant to subsection (c) of section 506 as the State to which authority has been delegated in connection with such plan; or

"(ii) if there is no State referred to in clause (i), the Secretary.

"(B) EXCEPTIONS.—

"(i) JOINT AUTHORITIES.—Where such term appears in section 808(3), section 807(e) (in the first instance), section 809(a) (in the second instance), section 809(a) (in the fourth instance), and section 809(b)(1), such term means, in connection with an association health plan, the Secretary and the State referred to in subparagraph (A)(i) (if any) in connection with such plan.

"(ii) REGULATORY AUTHORITIES.—Where such term appears in section 802(a) (in the first instance), section 802(d), section 802(e), section 803(d), section 805(a)(5), section 806(a)(2), section 806(b), section 806(c), section 806(d), paragraphs (1)(A) and (2)(A) of section 806(g), section 806(h), section 806(i), section 806(j), section 807(a) (in the second instance), section 807(b), section

807(d), section 807(e) (in the second instance), section 808 (in the matter after paragraph (3)), and section 809(a) (in the third instance), such term means, in connection with an association health plan, the Secretary.

"(6) HEALTH STATUS-RELATED FACTOR.—The term 'health status-related factor' has the meaning provided in section 733(d)(2).

"(7) INDIVIDUAL MARKET.—

"(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"(B) TREATMENT OF VERY SMALL GROUPS.—

"(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

"(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

"(8) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

"(9) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

"(10) QUALIFIED ACTUARY.—The term 'qualified actuary' means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation through negotiated rulemaking.

"(11) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

"(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor,

"(B) in the case of a sponsor with members which consist of associations, a person who is a member of any such association and elects an affiliated status with the sponsor, or

"(C) in the case of an association health plan in existence on the date of the enactment of the Bipartisan Patient Protection Act, a person eligible to be a member of the sponsor or one of its member associations.

"(12) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

"(13) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, an employer who is not a large employer.

"(b) RULES OF CONSTRUCTION.—

"(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

"(A) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

"(B) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

"(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.".

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

"(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.".

(2) Section 514 of such Act (29 U.S.C. 1144), as amended by section 142, is amended—

(A) in subsection (b)(4), by striking "Subsection (a)" and inserting "Subsections (a) and (e)";

(B) in subsection (b)(5), by striking "subsection (a)" in subparagraph (A) and inserting "subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805", and

by striking "subsection (a)" in subparagraph (B) and inserting "subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805";

(C) by redesignating subsection (e) as subsection (f); and

(D) by inserting after subsection (d) the following new subsection:

"(e)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude, or have the effect of precluding, a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

"(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

"(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

"(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

"(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

"(4) For purposes of this subsection, the term 'association health plan' has the meaning provided in section 801(a), and the terms 'health insurance coverage', 'participating employer', and 'health insurance issuer' have the meanings provided such terms in section 811, respectively.".

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking "and" at the end;

(B) in clause (ii), by inserting "and which does not provide medical care (within the meaning of section 733(a)(2))," after "arrangement,", and by striking "title." and inserting "title, and"; and

(C) by adding at the end the following new clause:

"(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.".

(4) Section 514(e) of such Act (as redesignated by paragraph (2)(C)) is amended—

(A) by striking "Nothing" and inserting "(1) Except as provided in paragraph (2), nothing"; and

(B) by adding at the end the following new paragraph:

"(2) Nothing in any other provision of law enacted on or after the date of the enactment of the Bipartisan Patient Protection Act shall be construed to alter, amend, modify, invalidate, impair, or supersede any provision of this title, except by specific cross-reference to the affected section.".

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: "Such term also includes a person serving as the sponsor of an association health plan under part 8.".

(d) DISCLOSURE OF SOLVENCY PROTECTIONS RELATED TO SELF-INSURED AND FULLY INSURED OPTIONS UNDER ASSOCIATION HEALTH PLANS.—Section 102(b) of such Act (29 U.S.C. 102(b)) is amended by adding at the end the following: "An association health plan shall include in its summary plan description, in connection with each benefit option, a description of the form of solvency or guarantee fund protection secured pursuant to this Act or applicable State law, if any.".

(e) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting "or part 8" after "this part".

(f) REPORT TO THE CONGRESS REGARDING CERTIFICATION OF SELF-INSURED ASSOCIATION HEALTH PLANS.—Not later than January 1, 2006, the Secretary of Labor shall report to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate the effect association health plans have had, if any, on reducing the number of uninsured individuals.

(g) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

"PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

"Sec. 801. Association health plans.
"Sec. 802. Certification of association health plans.
"Sec. 803. Requirements relating to sponsors and boards of trustees.
"Sec. 804. Participation and coverage requirements.
"Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.
"Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.
"Sec. 807. Requirements for application and related requirements.
"Sec. 808. Notice requirements for voluntary termination.
"Sec. 809. Corrective actions and mandatory termination.
"Sec. 810. Trusteeship by the Secretary of insolvent association health plans providing health benefits in addition to health insurance coverage.
"Sec. 811. State assessment authority.
"Sec. 812. Definitions and rules of construction.".

SEC. 422. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting "for any plan year of any such plan, or any fiscal year of any such other arrangement;" after

"single employer", and by inserting "during such year or at any time during the preceding 1-year period" after "control group";

(2) in clause (iii)—

(A) by striking "common control shall not be based on an interest of less than 25 percent" and inserting "an interest of greater than 25 percent may not be required as the minimum interest necessary for common control"; and

(B) by striking "similar to" and inserting "consistent and coextensive with";

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

"(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only one participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement;".

SEC. 423. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) IN GENERAL.—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

"(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E);".

(b) LIMITATIONS.—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

"(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

"(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

"(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

"(II) pay any type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations prescribed by the Secretary through negotiated rulemaking), that is related either to the volume or number of employers or individuals solicited or enrolled as par-

ticipating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

"(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are neither—

"(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

"(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Bipartisan Patient Protection Act and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

"(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed by the Secretary through negotiated rulemaking that the plan or other arrangement meets the requirements of clauses (i) and (ii).

"(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

"(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

"(ii)(I) the plan or arrangement is a multiemployer plan; and

"(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

"(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

"(i) the plan or arrangement is in effect as of the date of the enactment of the Bipartisan Patient Protection Act; or

"(ii) the employee organization or other entity sponsoring the plan or arrangement—

"(I) has been in existence for at least 3 years; or

"(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.".

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: "Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).".

SEC. 424. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting "(a)" after "SEC. 501."; and

(2) by adding at the end the following new subsection:

"(b) Any person who willfully falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

"(1) being an association health plan which has been certified under part 8;

"(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

"(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both.".

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132), as amended by sections 141 and 143, is further amended by adding at the end the following new subsection:

"(p) ASSOCIATION HEALTH PLAN CEASE AND DESIST ORDERS.—

"(1) IN GENERAL.—Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

"(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not

licensed, registered, or otherwise approved under the insurance laws of such State; or

"(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

"(2) EXCEPTION.—Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

"(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

"(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

"(3) ADDITIONAL EQUITABLE RELIEF.—The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.".

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133), as amended by section 301(b), is amended by adding at the end the following new subsection:

"(c) ASSOCIATION HEALTH PLANS.—The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.".

SEC. 425. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

"(c) CONSULTATION WITH STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

"(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—

"(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

"(B) the Secretary's authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

"(2) RECOGNITION OF PRIMARY DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular association health plan, as the State to with which consultation is required. In carrying out this paragraph, the Secretary shall take into account the places of residence of the participants and beneficiaries under the plan and the State in which the trust is maintained.".

SEC. 426. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 421, 424, and 425 shall take effect one year from the date of enactment. The amendments made by sections 422 and 423 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this subtitle within one year from the date of enactment. Such regulations shall be issued through negotiated rulemaking.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 421) does not apply in connection with an association health plan (certified under part 8 of subtitle B of title I of such Act) existing on the date of the enactment of this Act, if no benefits provided thereunder as of the date of the enactment of this Act consist of health insurance coverage (as defined in section 733(b)(1) of such Act).

(c) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 812(a)(5) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a)(1) and 803(a)(1) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of directors which—

(i) is elected by the participating employers, with each employer having one vote; and

(ii) has complete fiscal control over the arrangement and which is responsible for all operations of the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement.

(2) DEFINITIONS.—For purposes of this subsection, the terms "group health plan", "medical care", and "participating employer" shall have the meanings provided in section 812 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an "association health plan" shall be deemed a reference to an arrangement referred to in this subsection.

Amend section 511 to read as follows (and conform the table of contents accordingly):

SEC. 511. EXPANSION OF AVAILABILITY OF ARCHER MEDICAL SAVINGS ACCOUNTS.

(a) REPEAL OF LIMITATIONS ON NUMBER OF MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Subsections (i) and (j) of section 220 of the Internal Revenue Code of 1986 are hereby repealed.

(2) CONFORMING AMENDMENTS.—

(A) Paragraph (1) of section 220(c) of such Code is amended by striking subparagraph (D).

(B) Section 138 of such Code is amended by striking subsection (f).

(b) AVAILABILITY NOT LIMITED TO ACCOUNTS FOR EMPLOYEES OF SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(1) of such Code (relating to eligible individual) is amended to read as follows:

"(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

"(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

"(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

"(I) which is not a high deductible health plan, and

"(II) which provides coverage for any benefit which is covered under the high deductible health plan.".

(2) CONFORMING AMENDMENTS.—

(A) Section 220(c)(1) of such Code is amended by striking subparagraph (C).

(B) Section 220(c) of such Code is amended by striking paragraph (4) (defining small employer) and by redesignating paragraph (5) as paragraph (4).

(C) Section 220(b) of such Code is amended by striking paragraph (4) (relating to deduction limited by compensation) and by redesignating paragraphs (5), (6), and (7) as paragraphs (4), (5), and (6), respectively.

(c) INCREASE IN AMOUNT OF DEDUCTION ALLOWED FOR CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Paragraph (2) of section 220(b) of such Code is amended to read as follows:

"(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the individual's coverage under the high deductible health plan.".

(2) CONFORMING AMENDMENT.—Clause (ii) of section 220(d)(1)(A) of such Code is amended by striking "75 percent of".

(d) BOTH EMPLOYERS AND EMPLOYEES MAY CONTRIBUTE TO MEDICAL SAVINGS ACCOUNTS.—Paragraph (4) of section 220(b) of such Code (as redesignated by subsection (b)(2)(C)) is amended to read as follows:

"(4) COORDINATION WITH EXCLUSION FOR EMPLOYER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the amount which would (but for section 106(b)) be includible in the taxpayer's gross income for such taxable year.".

(e) REDUCTION OF PERMITTED DEDUCTIBLES UNDER HIGH DEDUCTIBLE HEALTH PLANS.—

(1) IN GENERAL.—Subparagraph (A) of section 220(c)(2) of such Code (defining high deductible health plan) is amended—

(A) by striking "$1,500" in clause (i) and inserting "$1,000"; and

(B) by striking "$3,000" in clause (ii) and inserting "$2,000".

(2) CONFORMING AMENDMENT.—Subsection (g) of section 220 of such Code is amended to read as follows:

"(g) COST-OF-LIVING ADJUSTMENT.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subsection (c)(2) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 1997' for 'calendar year 1992' in subparagraph (B) thereof.

"(2) SPECIAL RULES.—In the case of the $1,000 amount in subsection (c)(2)(A)(i) and the $2,000 amount in subsection (c)(2)(A)(ii), paragraph (1)(B) shall be applied by substituting 'calendar year 2000' for 'calendar year 1997'.

"(3) ROUNDING.—If any increase under paragraph (1) or (2) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.".

(f) PROVIDING INCENTIVES FOR PREFERRED PROVIDER ORGANIZATIONS TO OFFER MEDICAL SAVINGS ACCOUNTS.—

(1) PREVENTIVE CARE COVERAGE PERMITTED.—Clause (ii) of section 220(c)(2)(B) of such Code is amended by striking "preventive care if" and all that follows and inserting "preventive care."

(2) TREATMENT OF NETWORK SERVICES.—Subparagraph (B) of section 220(c)(2) of such Code is amended by adding at the end the following new clause:

"(iii) TREATMENT OF NETWORK SERVICES.—In the case of a health plan which provides benefits for services provided by providers in a network (as defined in section 161 of the Patient's Bill of Rights Act of 2001) and which would (without regard to services provided by providers outside the network) be a high deductible

health plan, such plan shall not fail to be a high deductible health plan because—

"(I) the annual deductible for services provided by providers outside the network exceeds the applicable maximum dollar amount in clause (i) or (ii), or

"(II) the annual out-of-pocket expenses required to be paid for services provided by providers outside the network exceeds the applicable dollar amount in clause (iii).

The annual deductible taken into account under subsection (b)(2) with respect to a plan to which the preceding sentence applies shall be the annual deductible for services provided by providers within the network."

(g) MEDICAL SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Subsection (f) of section 125 of such Code is amended by striking "106(b),".

(h) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2001.

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2. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE NORWOOD OF GEORGIA, OR A DESIGNEE, DEBATABLE FOR 60 MINUTES

Amend section 402 to read as follows:

SEC. 402. AVAILABILITY OF CIVIL REMEDIES.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132) is amended by adding at the end the following:

"(n) CAUSE OF ACTION RELATING TO CLAIMS FOR HEALTH BENEFITS.—

"(1) CAUSE OF ACTION.—

"(A) IN GENERAL.—With respect to an action commenced by a participant or beneficiary (or the estate of the participant or beneficiary) in connection with a claim for benefits under a group health plan, if—

"(i) a designated decisionmaker described in paragraph (2) fails to exercise ordinary care—

"(I) in making a determination denying the claim for benefits under section 503A (relating to an initial claim for benefits),

"(II) in making a determination denying the claim for benefits under section 503B (relating to an internal appeal), or

"(III) in failing to authorize coverage in compliance with the written determination of an independent medical reviewer under section 503C(d)(3)(F) that reverses a determination denying the claim for benefits, and

"(ii) the delay in receiving, or failure to receive, benefits attributable to the failure described in clause (i) is the proximate cause of personal injury to, or death of, the participant or beneficiary,

such designated decisionmaker shall be liable to the participant or beneficiary (or the estate) for economic and non-

economic damages in connection with such failure and such injury or death (subject to paragraph (4)).

"(B) REBUTTABLE PRESUMPTION.—In the case of a cause of action under subparagraph (A)(i)(I) or (A)(i)(II), if an independent medical reviewer under section 503C(d) or 503C(e)(4)(B) upholds the determination denying the claim for benefits involved, there shall be a presumption (rebuttable by clear and convincing evidence) that the designated decisionmaker exercised ordinary care in making such determination.

"(2) DESIGNATED DECISIONMAKER.—

"(A) APPOINTMENT.—

"(i) IN GENERAL.—The plan sponsor or named fiduciary of a group health plan shall, in accordance with this paragraph with respect to a participant or beneficiary, designate a person that meets the requirements of subparagraph (B) to serve as a designated decisionmaker with respect to the cause of action described in paragraph (1), except that—

"(I) with respect to health insurance coverage offered in connection with a group health plan, the health insurance issuer shall be the designated decisionmaker unless the plan sponsor and the issuer specifically agree in writing (on a form to be prescribed by the Secretary) to substitute another person as the designated decisionmaker; or

"(II) with respect to the designation of a person other than a plan sponsor or health insurance issuer, such person shall satisfy the requirements of subparagraph (D).

"(ii) PLAN DOCUMENTS.—The designated decisionmaker shall be specifically designated as such in the written instruments of the plan (under section 402(a)) and be identified as required under section 121(b)(15) of the Bipartisan Patient Protection Act.

"(B) REQUIREMENTS.—For purposes of this paragraph, a designated decisionmaker meets the requirements of this subparagraph with respect to any participant or beneficiary if—

"(i) such designation is in such form as may be specified in regulations prescribed by the Secretary,

"(ii) the designated decisionmaker—

"(I) meets the requirements of subparagraph (C),

"(II) assumes unconditionally all liability arising under this subsection in connection with actions and failures to act described in subparagraph (A) (whether undertaken by the designated decisionmaker or the employer, plan, plan sponsor, or employee or agent thereof) during the period in which the designation under this paragraph is in effect relating to such participant or beneficiary, and

"(III) where subparagraph (C)(ii) applies, assumes unconditionally the exclusive authority under the group health plan to make determinations on claims for benefits (irrespective of whether they constitute medically reviewable determinations) under the plan with respect to such participant or beneficiary, and

"(iii) the designated decisionmaker and the participants and beneficiaries for whom the decisionmaker has assumed liability are identified in the written instrument required under section 402(a) and as required under section 121(b)(15) of the Bipartisan Patient Protection Act.

Any liability assumed by a designated decisionmaker pursuant to this paragraph shall be in addition to any liability that it may otherwise have under applicable law.

"(C) QUALIFICATIONS FOR DESIGNATED DECISIONMAKERS.—

"(i) IN GENERAL.—Subject to clause (ii), an entity is qualified under this subparagraph to serve as a designated decisionmaker with respect to a group health plan if the entity has the ability to assume the liability described in subparagraph (A) with respect to participants and beneficiaries under such plan, including requirements relating to the financial obligation for timely satisfying the assumed liability, and maintains with the plan sponsor certification of such ability. Such certification shall be provided to the plan sponsor or named fiduciary upon designation under this paragraph and not less frequently than annually thereafter, or if such designation constitutes a multiyear arrangement, in conjunction with the renewal of the arrangement.

"(ii) SPECIAL QUALIFICATION IN THE CASE OF CERTAIN REVIEWABLE DECISIONS.—In the case of a group health plan that provides benefits consisting of medical care to a participant or beneficiary only through health insurance coverage offered by a health insurance issuer, such issuer is the only entity that may be qualified under this subparagraph to serve as a designated decisionmaker with respect to such participant or beneficiary, and shall serve as the designated decisionmaker unless the employer or other plan sponsor acts affirmatively to prevent such service.

"(D) REQUIREMENTS RELATING TO FINANCIAL OBLIGATIONS.—For purposes of subparagraphs (A)(i)(II) and (C)(i), the requirements relating to the financial obligation of an entity for liability shall include—

"(i) coverage of such entity under an insurance policy or other arrangement, secured and maintained by such entity, to effectively insure such entity against losses arising from professional liability claims, including those arising from its service as a designated decisionmaker under this subsection; or

"(ii) evidence of minimum capital and surplus levels that are maintained by such entity to cover any losses as a result of liability arising from its service as a designated decisionmaker under this subsection.

The appropriate amounts of liability insurance and minimum capital and surplus levels for purposes of clauses (i) and (ii) shall be determined by an actuary using sound actuarial principles and accounting practices pursuant to established guidelines of the American Academy of Actuaries and in accordance with such regulations as the Secretary may prescribe and shall be maintained throughout the term for which the designation is in effect. The provisions of this subparagraph shall not apply in the case of a designated decisionmaker that is a group health plan, plan sponsor, or health insurance issuer and that is regulated under Federal law or a State financial solvency law.

"(E) LIMITATION ON APPOINTMENT OF TREATING PHYSICIANS.—A treating physician who directly delivered the care or treatment or provided services which is the subject of a cause of action by a participant or beneficiary under paragraph (1) may not be appointed (or deemed to be appointed) as a designated decisionmaker under this paragraph with respect to such participant or beneficiary.

"(F) FAILURE TO APPOINT.—With respect to any cause of action under paragraph (1) relating to a denial of a claim for benefits where a designated decisionmaker has not been appointed in accordance with this paragraph, the plan sponsor or named fiduciary responsible for determinations under section 503 shall be deemed to be the designated decisionmaker.

"(G) EFFECT OF APPOINTMENT.—The appointment of a designated decisionmaker in accordance with this paragraph shall not affect the liability of the appointing plan sponsor or named fiduciary for the failure of the plan sponsor or named fiduciary to comply with any other requirement of this title.

"(H) TREATMENT OF CERTAIN TRUST FUNDS.—For purposes of this subsection, the terms 'employer' and 'plan sponsor', in connection with the assumption by a designated decisionmaker of the liability of employer or other plan sponsor pursuant to this paragraph, shall be construed to include a trust fund maintained pursuant to section 302 of the Labor Management Relations Act, 1947 (29 U.S.C. 186) or the Railway Labor Act (45 U.S.C. 151 et seq.).

"(3) REQUIREMENT OF EXHAUSTION OF INDEPENDENT MEDICAL REVIEW.—

"(A) IN GENERAL.—Paragraph (1) shall apply only if—

"(i) a final determination denying a claim for benefits under section 503B has been referred for independent medical review under section 503C(d) and a written determination by an independent medical reviewer has been issued with respect to such review, or

"(ii) the qualified external review entity has determined under section 503C(c)(3) that a referral to an independent medical reviewer is not required.

"(B) INJUNCTIVE RELIEF FOR IRREPARABLE HARM.—A participant or beneficiary may seek relief under subsection (a)(1)(B) prior to the exhaustion of administrative remedies under section 503B or 503C (as required under subparagraph (A)) if it is demonstrated to the court, by a preponderance of the evidence, that the exhaustion of such remedies would cause irreparable harm to the health of the participant or beneficiary. Any determinations that already have been made under section 503A, 503B, or 503C in such case, or that are made in such case while an action under this subparagraph is pending, shall be given due consideration by the court in any action under subsection (a)(1)(B) in such case. Notwithstanding the awarding of such relief under subsection (a)(1)(B) pursuant to this subparagraph, no relief shall be available under paragraph (1), with respect to a participant or beneficiary, unless the requirements of subparagraph (A) are met.

"(C) RECEIPT OF BENEFITS DURING APPEALS PROCESS.—Receipt by the participant or beneficiary of the benefits involved in the claim for benefits during the pendency of any administrative processes referred to in subparagraph (A) or of any action commenced under this subsection—

"(i) shall not preclude continuation of all such administrative processes to their conclusion if so moved by any party, and

"(ii) shall not preclude any liability under subsection (a)(1)(C) and this subsection in connection with such claim.

The court in any action commenced under this subsection shall take into account any receipt of benefits during such administrative processes or such action in determining the amount of the damages awarded.

"(4) LIMITATIONS ON RECOVERY OF DAMAGES.—

"(A) MAXIMUM AWARD OF NONECONOMIC DAMAGES.—The aggregate amount of liability for noneconomic loss in an action under paragraph (1) may not exceed $1,500,000.

"(B) LIMITATION ON AWARD OF PUNITIVE DAMAGES.—In the case of any action commenced pursuant to paragraph (1), the court may not award any punitive, exemplary, or similar damages against a defendant, except that the court may award punitive, exemplary, or similar damages (in addition to damages described in subparagraph (A)), in an aggregate amount not to exceed $1,500,000, if—

"(i) the denial of a claim for benefits involved in the case was reversed by a written determination by an independent medical reviewer under section 503C(d)(3)(F); and

"(ii) there has been a failure to authorize coverage in compliance with such written determination.

"(C) PERMITTING APPLICATION OF LOWER STATE DAMAGE LIMITS.—A State may limit damages for noneconomic loss or punitive, exemplary, or similar damages in an action

under paragraph (1) to amounts less than the amounts permitted under this paragraph.

"(5) ADMISSIBILITY.—In an action described in subclause (I) or (II) of paragraph (1)(A) relating to a denial of a claim for benefits, any determination by an independent medical reviewer under section 503C(d) or 503C(e)(4)(B) relating to such denial is admissible.

"(6) WAIVER OF INTERNAL REVIEW.—In the case of any cause of action under paragraph (1), the waiver or nonwaiver of internal review under section 503B(a)(4) by the group health plan, or health insurance issuer that offers health insurance coverage in connection with a group health plan, shall not be used in determining liability.

"(7) LIMITATIONS ON ACTIONS.—Paragraph (1) shall not apply in connection with any action that is commenced more than 5 years after the date on which the failure described in such paragraph occurred or, if earlier, not later than 2 years after the first date the participant or beneficiary became aware of the personal injury or death referred to in such paragraph.

"(8) EXCLUSION OF DIRECTED RECORDKEEPERS.—

"(A) IN GENERAL.—Paragraph (1) shall not apply with respect to a directed record keeper in connection with a group health plan.

"(B) DIRECTED RECORDKEEPER.—For purposes of this paragraph, the term 'directed recordkeeper' means, in connection with a group health plan, a person engaged in directed recordkeeping activities pursuant to the specific instructions of the plan, the employer, or another plan sponsor, including the distribution of enrollment information and distribution of disclosure materials under this Act or title I of the Bipartisan Patient Protection Act and whose duties do not include making determinations on claims for benefits.

"(C) LIMITATION.—Subparagraph (A) does not apply in connection with any directed recordkeeper to the extent that the directed recordkeeper fails to follow the specific instruction of the plan or the employer or other plan sponsor.

"(9) PROTECTION OF THE REGULATION OF QUALITY OF MEDICAL CARE UNDER STATE LAW.—Nothing in this subsection shall be construed to preclude any action under State law against a person or entity for liability or vicarious liability with respect to the delivery of medical care. A cause of action that is based on or otherwise relates to a group health plan's determination on a claim for benefits shall not be deemed to be the delivery of medical care under any State law for purposes of this paragraph. Any such cause of action shall be maintained exclusively under this section. Nothing in this paragraph shall be construed to alter, amend, modify, invalidate, impair, or supersede section 514.

"(10) COORDINATION WITH FIDUCIARY REQUIREMENTS.—A fiduciary shall not be treated as failing to meet any requirement of part 4 solely by reason of any action taken by a fiduciary which consists of full compliance with the reversal under section 503C (relating to independent external appeals procedures

for group health plans) of a denial of claim for benefits (within the meaning of section 503C(i)(2)).

"(11) CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing a cause of action under paragraph (1) for the failure of a group health plan or health insurance issuer to provide an item or service that is specifically excluded under the plan or coverage.

"(12) LIMITATION ON CLASS ACTION LITIGATION.—A claim or cause of action under this subsection may not be maintained as a class action, as a derivative action, or as an action on behalf of any group of 2 or more claimants.

"(13) PURCHASE OF INSURANCE TO COVER LIABILITY.—Nothing in section 410 shall be construed to preclude the purchase by a group health plan of insurance to cover any liability or losses arising under a cause of action under subsection (a)(1)(C) and this subsection.

"(14) RETROSPECTIVE CLAIMS FOR BENEFITS.—A cause of action shall not arise under paragraph (1) where the claim for benefits relates to an item or service that has already been provided to the participant or beneficiary under the plan or coverage and the claim relates solely to the subsequent denial of payment for the provision of such item or service.

"(15) EXEMPTION FROM PERSONAL LIABILITY FOR INDIVIDUAL MEMBERS OF BOARDS OF DIRECTORS, JOINT BOARDS OF TRUSTEES, ETC.—Any individual who is—

"(A) a member of a board of directors of an employer or plan sponsor; or

"(B) a member of an association, committee, employee organization, joint board of trustees, or other similar group of representatives of the entities that are the plan sponsor of plan maintained by two or more employers and one or more employee organizations;

shall not be personally liable under this subsection for conduct that is within the scope of employment or of plan-related duties of the individuals unless the individual acts in a fraudulent manner for personal enrichment.

"(16) DEFINITIONS AND RELATED RULES.—For purposes of this subsection:

"(A) CLAIM FOR BENEFITS.—The term 'claim for benefits' shall have the meaning given such term in section 503A(e).

"(B) GROUP HEALTH PLAN.—The term 'group health plan' shall have the meaning given such term in section 733(a).

"(C) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning given such term in section 733(b)(1).

"(D) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term in section 733(b)(2).

"(E) ORDINARY CARE.—The term 'ordinary care' means, with respect to a determination on a claim for benefits, that degree of care, skill, and diligence that a reasonable and prudent individual would exercise in making a fair determination on a claim for benefits of like kind to the claims involved.

"(F) PERSONAL INJURY.—The term 'personal injury' means a physical injury and includes an injury arising out of the treatment (or failure to treat) a mental illness or disease.

"(G) TREATMENT OF EXCEPTED BENEFITS.—The provisions of this subsection (and subsection (a)(1)(C)) shall not apply to excepted benefits (as defined in section 733(c)), other than benefits described in section 733(c)(2)(A), in the same manner as the provisions of part 7 do not apply to such benefits under subsections (b) and (c) of section 732.

(2) CONFORMING AMENDMENT.—Section 502(a)(1) of such Act (29 U.S.C. 1132(a)(1)) is amended—

(A) by striking "or" at the end of subparagraph (A);

(B) in subparagraph (B), by striking "plan;" and inserting "plan, or"; and

(C) by adding at the end the following new subparagraph:

"(C) for the relief provided for in subsection (n) of this section.".

(b) AVAILABILITY OF ACTIONS IN STATE COURT.—

(1) JURISDICTION OF STATE COURTS.—Section 502(e)(1) of such Act (29 U.S.C. 1132(e)) is amended—

(A) in the first sentence, by striking "subsection (a)(1)(B)" and inserting "paragraphs (1)(B), (1)(C), and (7) of subsection (a)";

(B) in the second sentence, by striking "paragraphs (1)(B) and (7)" and inserting "paragraphs (1)(B), (1)(C), and (7)"; and

(C) by adding at the end the following new sentence: "State courts of competent jurisdiction in the State in which the plaintiff resides and district courts of the United States shall have concurrent jurisdiction over actions under subsections (a)(1)(C) and (n).".

(2) LIMITATION ON REMOVABILITY OF CERTAIN ACTIONS IN STATE COURT.—Section 1445 of title 28, United States Code, is amended by adding at the end the following new subsection:

"(e)(1) A civil action brought in any State court under subsections (a)(1)(C) and (n) of section 502 of the Employee Retirement Income Security Act of 1974 against any party (other than the employer, plan, plan sponsor, or other entity treated under section 502(n) of such Act as such) arising from a medically reviewable determination may not be removed to any district court of the United States.

"(2) For purposes of paragraph (1), the term 'medically reviewable decision' means a denial of a claim for benefits under the plan which is described in section 503C(d)(2) of the Employee Retirement Income Security Act of 1974.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to acts and omissions, from which a cause of action arises, occurring on or after the applicable effective date under section 601.

Amend section 403 to read as follows:

SEC. 403. LIMITATION ON CERTAIN CLASS ACTION LITIGATION.

(a) IN GENERAL.—Section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132), as amended by section 402, is further amended by adding at the end the following:

"(o) LIMITATION ON CLASS ACTION LITIGATION.—Any claim or cause of action that is maintained under this section (other than under subsection (n)) or under section 1962 or 1964(c) of title 18, United States Code, in connection with a group health plan, or health insurance coverage issued in connection with a group health plan, as a class action, derivative action, or as an action on behalf of any group of 2 or more claimants, may be maintained only if the class, the derivative claimant, or the group of claimants is limited to the participants or beneficiaries of a group health plan established by only 1 plan sponsor. No action maintained by such class, such derivative claimant, or such group of claimants may be joined in the same proceeding with any action maintained by another class, derivative claimant, or group of claimants or consolidated for any purpose with any other proceeding. In this paragraph, the terms 'group health plan' and 'health insurance coverage' have the meanings given such terms in section 733.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to actions commenced on or after August 2, 2001. Notwithstanding the preceding sentence, with respect to class actions, the amendment made by subsection (a) shall apply with respect to civil actions which are pending on such date in which a class action has not been certified as of such date.

Amend section 603 to read as follows:

SEC. 603. SEVERABILITY.

(a) IN GENERAL.—Except as provided in subsections (b) and (c), if any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

(b) DEPENDENCE OF REMEDIES ON APPEALS.—If any provision of section 503A, 503B, or 503C of the Employee Retirement Income Security Act of 1974 (as inserted by section 131) or the application of either such section to any person or circumstance is held to be unconstitutional, section 502(n) of such Act (as inserted by section 402) shall be deemed to be null and void and shall be given no force or effect.

(c) REMEDIES.—If any provision of section 502(n) of the Employee Retirement Income Security Act of 1974 (as inserted by section 402), or the application of such section to any person or circumstance, is held to be unconstitutional, the remainder of such section shall be deemed to be null and void and shall be given no force or effect.

Page 16, line 10, strike "on a timely basis" and insert "in accordance with the applicable deadlines established under this section and section 503B".

Page 29, line 14, strike "or modify".

Page 36, line 12, strike "upheld, reversed, or modified" and insert "upheld or reversed".

Page 39, line 23, strike "uphold, reverse, or modify" and insert "uphold or reverse".

Page 40, line 8, and page 44, line 9, strike "or modify".

Page 23, line 18; page 41, line 19; page 43, line 2; , , strike "reviewer (or reviewers)" and insert "a review panel".

Page 33, line 7, strike "reviewer" and insert "review panel".

Page 34, line 25, strike "reviewer" and insert "review panel composed of 3 independent medical reviewers".

Page 34, lines 8 and 13; page 36, line 8; page 37, line 3; page 38, lines 6 and 20; page 39, line 4, 20, and 21; page 40, lines 1, 2 and 14; page 41, line 6; page 43, lines 6, 17, and 20; page 44, lines 5, 9, and 14; page 45, line 24; page 61, line 5; page 67, line 3; page 68, line 25; , strike "reviewer" and insert "review panel".

Page 36, line 14; page 43, line 21; page 44, line 12; , strike "reviewer's" and insert "review panel's".

Page 41, line 4, strike "reviewer (or reviewers)" and insert "review panel".

Page 47, line 15, strike "independent external reviewer" and insert "independent medical review panel".

Page 50, line 20, strike "1 or more individuals" and insert "an independent medical review panel".

Page 51, amend lines 4 through 6 to read as follows:

> "(B) with respect to each review, the review panel meets the requirements of paragraph (4) and at least 1 reviewer on the panel meets the requirements described in paragraph (5); and

Page 51, line 8, strike "the reviewer" and insert "each reviewer".

Page 53, line 21, strike "a reviewer" and insert "each reviewer".

Page 54, line 6, strike "a reviewer (or reviewers)" and insert "the independent medical review panel".

Page 61, line 5, insert "or any independent medical review panel" after "reviewer".

Page 64, lines 1 and 5, strike "reviewers" and insert "review panel".

Page 64, line 14; page 69, lines 16 and 19, strike "reviewers" and insert "review panels".

Page 8, after line 17, insert the following (and place the text from page 8, line 18, through page 16, line 20 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 503 (29 U.S.C. 1133) the following:

"SEC. 503A. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.

Page 16, after line 21, insert the following (and place the text from page 16, line 22, through page 25, line 13 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by section 102) is amended further by inserting after section 503A (29 U.S.C. 1133) the following:

"SEC. 503B. INTERNAL APPEALS OF CLAIMS DENIALS.

Page 25, after line 15, insert the following (and place the text from page 25, line 16, through page 69, line 22 in quotation marks):

Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (as amended by sections 102 and 103) is amended further by inserting after section 503B (29 U.S.C. 1133) the following:

"SEC. 503C. INDEPENDENT EXTERNAL APPEALS PROCEDURES.

Page 119, line 1, insert after "treatment." the following: "The name of the designated decisionmaker (or decisionmakers) appointed under paragraph (2) of section 502(n) of the Employee Retirement Income Security Act of 1974 for purposes of such section.".

Page 138, line 21, insert after "plan" the following: "and only with respect to patient protection requirements under section 101 and subtitles B, C, and D and this subtitle".

Page 145, line 12, strike "and the provisions of sections 502(a)(1)(C), 502(n), and 514(d) of the Employee Retirement Income Security Act of 1974 (added by section 402)".

Page 148, line 15, after "Act" insert the following: "and sections 503A through 503C of the Employee Retirement Income Security Act of 1974".

Page 149, line 9, after "Act" insert the following: "and sections 503A through 503C of the Employee Retirement Income Security Act of 1974 (with respect to enrollees under individual health insurance coverage in the same manner as they apply to participants and beneficiaries under group health insurance coverage)".

Page 152, line 16, insert "section 101 and subtitles B, C, D, and E of" before "title I".

Page 155, strike lines 1 through 19 (and redesignate the subsequent paragraphs accordingly).

Page 158, strike lines 19 through 25 and insert the following:

"(b)(1)(A) Subject to subparagraphs (B) and (C), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of sections 503A, 503B, and 503C, and such requirements shall be deemed to be incorporated into this subsection.

"(B) With respect to the internal appeals process required to be established under section 503B, in the case of a group health plan that provides benefits in the form of health insurance coverage through a health insurance issuer, the Secretary shall determine the circumstances under which the plan is not required to provide for such process and system (and is not liable for the issuer's failure to provide for such process and system), if the issuer is obligated to provide for (and provides for) such process and system.

"(C) Pursuant to rules of the Secretary, insofar as a group health plan enters into a contract with a qualified external review entity for the conduct of external appeal activities in accordance with section 503C, the plan shall be treated as meeting the requirement of such section and is not liable for the entity's failure to meet any requirements under such section.

"(2) In the case of a group health plan, compliance with the requirements of sections 503A, 503B, and 503C, and compliance with regulations promulgated by the Secretary, in connection with a denial of a claim under a group health plan shall be deemed compliance with subsection (a) with respect to such claim denial.

"(3) Terms used in this subsection which are defined in section 733 shall have the meanings provided such terms in such section.".

Page 210, line 19, after "Act" insert the following: "and sections 503A through 503C of the Employee Retirement Income Security Act of 1974".

Make such additional technical and conforming changes to the text of the bill as are necessary to do the following:

(1) Replace references to sections 102, 103, and 104 of the bill with references to sections 503A, 503B, and 503C of the Employee Retirement Income Security Act of 1974, as amended by the bill.

(2) In sections 102, 103, and 104, strike any reference to "enrollee" or "enrollees" and insert "in connection with the group health plan" after "health insurance coverage", and make necessary conforming grammatical changes.

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3. AN AMENDMENT TO BE OFFERED BY REPRESENTATIVE THOMAS OF CALIFORNIA, OR REPRESENTATIVE SENSENBRENNER OF WISCONSIN, OR A DESIGNEE, DEBATABLE FOR 40 MINUTES

Add at the end the following new title (and amend the table of contents of the bill accordingly):

TITLE VIII—REFORMS RELATING TO HEALTH CARE LIABILITY CLAIMS

SEC. 801. TABLE OF CONTENTS OF TITLE.

The table of contents of this title is as follows:

SEC. 802. APPLICATION IN STATES.

The provisions of this title relating to any requirement or rule shall not apply with respect to a health care lawsuit brought under State law insofar as the applicable statutory law of that State with respect to such lawsuit specifies another policy with respect to such requirement or rule.

SEC. 803. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

Health care lawsuits shall be commenced no later than 2 years after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury for which the lawsuit was brought. In all cases, a health care lawsuit shall be filed no later than 5 years after the date of the injury. The time periods for filing health care lawsuits established in this section shall not apply in cases of malicious intent to injure. To the extent that chapter 171 of title 28, United States Code, relating to tort procedure, and, subject to section 802, State law (with respect to both procedural and substantive matters), establishes a longer period during which a health care lawsuit may be initiated than is authorized in this section, such chapter or law is superceded or preempted.

SEC. 804. COMPENSATING PATIENT INJURY; FAIR SHARE RULE.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, the full

amount of a claimant's economic loss may be fully recovered, subject to section 809(d)(2), without limitation.

(b) ADDITIONAL NON-ECONOMIC DAMAGES.—Subject to section 809(d)(2), in any health care lawsuit, the amount of non-economic damages may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(c) NO DISCOUNT OF AWARD FOR NON-ECONOMIC DAMAGES.—In any health care lawsuit, an award for future non-economic damages shall not be discounted to present value. The jury shall not be informed of the maximum award for non-economic damages. An award for non-economic damages in excess of the amount specified in subsection (b) (or the amount provided under section 809(d)(2), if applicable) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future non-economic damages and the combined awards exceed the amount so specified, the future non-economic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for the party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

(e) ADDITIONAL HEALTH BENEFITS.—In any health care lawsuit, any party may introduce evidence of collateral source benefits. If any party elects to introduce such evidence, the opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of such opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated to the right of the claimant in a health care lawsuit. This subsection shall apply to a health care lawsuit that is settled as well as a health care lawsuit that is resolved by a fact finder.

(f) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care lawsuit in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm; or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) APPLICABILITY.—This subsection shall apply to any such health care lawsuit on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages.

(3) LIMITATION ON PUNITIVE DAMAGES.—The total amount of punitive damages that may be awarded to a claimant for losses resulting from the injury which is the subject of such a health care lawsuit may not exceed the greater of—

(A) 2 times the amount of economic damages, or

(B) $250,000,

regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury. Subject to section 802, this subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(g) LIMITATIONS ON APPLICABILITY OF THIS SECTION.—This section applies only to health care lawsuits. Furthermore only to the extent that—

(1) chapter 171 of title 28, United States Code, relating to tort procedure, permits the recovery of a greater amount of damages than authorized by this section, such chapter shall be superseded by this section; and

(2) only to the extent that either chapter 171 of title 28, United States Code, relating to tort procedure, or, subject to section 802, State law (with respect to procedural and substantive matters), prohibits the introduction of evidence regarding collateral source benefits or mandates or permits subrogation or a lien on an award of damages for the cost of providing collateral source benefits, such chapter or law is superseded or preempted by this section.

SEC. 805. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a period payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws in July 1990. This section applies to all actions which have not been first set for trial or retrial prior to the effective date of this title.

(b) LIMITATION ON APPLICABILITY OF THIS SECTION.—Only to the extent that chapter 171 of title 28, United States Code, relating to tort procedure, or, subject to section 802, State law (with respect to both procedural and substantive matters), reduces the applicability or scope of the regulation of periodic payment of future damages as authorized in this section, is such chapter or law preempted or superseded.

SEC. 806. NO PUNITIVE DAMAGES FOR HEALTH CARE PRODUCTS THAT COMPLY WITH FDA STANDARDS.

(a) GENERAL RULE.—In the case of any health care lawsuit, no punitive or exemplary damages may be awarded against the manufacturer of a medical product based on a claim that the medical product caused the claimant's harm if the medical product complies with FDA standards.

(b) EXCEPTION.—Subsection (a) shall not apply in any health care lawsuit in which—

(1) before or after the grant of FDA permission to market a medical product, a person knowingly misrepresents to or withholds from the FDA required information that is material and relevant to the performance of such medical product, if such misrepresentation or withholding of information is causally related to the harm which the claimant allegedly suffered; or

(2) a person makes an illegal payment to an official of FDA for the purpose of either securing or maintaining approval of such medical product.

SEC. 807. EFFECT ON OTHER LAWS.

This title does not affect the application of title XXI of the Public Health Service Act (relating to the national vaccine program). To the extent that this title is judged to be in conflict with such title XXI, then this title shall not apply to an action brought under such title. If any aspect of such a civil action is not governed by a Federal rule of law under such title, then this title or otherwise applicable law (as determined under this title) will apply to that aspect of the action.

SEC. 808. DEFINITIONS.

As used in this title:

(1) ALTERNATIVE DISPUTE RESOLUTION.—The term "alternative dispute resolution" means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal Court.

(2) AMOUNT RECOVERED BY CLAIMANTS.—The term "amount recovered by claimants" means the total amount of damages awarded to a party, after taking into account any reduction in damages required by this title or applicable law, and after deducting any disbursements or costs incurred in connection with prosecution or settlement of a claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose. Such term does not include any punitive or exemplary damages.

(3) CLAIMANT.—The term "claimant" means any person who asserts a health care liability claim or brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity, or subrogation, arising out of a health care lawsuit, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(4) COLLATERAL SOURCE BENEFITS.—The term "collateral source benefits" means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely

to be provided in the future to or on behalf of the claimant, as a result of injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(5) COMPLIES WITH FDA STANDARDS.—The term "complies with FDA standards" means, in the case of any medical product, that such product is either—

(A) subject to pre-market approval or review by the Food and Drug Administration under section 505, 506, 510, 515 or 520 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 356, 360, 360e, 360j) or section 351 of the Public Health Service Act (42 U.S.C. 262) and such approval or review concerns the adequacy of the packaging or labeling of such medical product or the safety of the formulation or performance of any aspect of such medical product which a health care lawsuit claims caused the claimant's harm, and such medical product was marketed in conformity with the regulations under such sections, or

(B) generally recognized as safe and effective pursuant to conditions established by the FDA and applicable FDA regulations, including those related to packaging and labeling.

(6) CONTINGENT FEE.—The term "contingent fee" includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(7) ECONOMIC LOSS.—The term "economic loss" means reasonable amounts incurred for necessary health treatment and medical expenses, lost wages, replacement service losses, and other pecuniary expenditures due to personal injuries suffered as a result of injury.

(8) FDA.—The term "FDA" means the Food and Drug Administration.

(9) HEALTH CARE GOODS OR SERVICES.—The term "health care goods or services" means any medical product, or any service provided by a health care provider or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(10) HEALTH CARE LAWSUIT.—The term "health care lawsuit" means any health care liability claim concerning the provision of health care goods or services, or any civil action concerning the provision of health care goods or services brought in a State or Federal Court or pursuant to an alternative dispute resolution procedure, against a health care provider or the manufacturer, distributor, supplier, marketer, promoter or seller of a medical product, regardless of the theory of liability on

which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term "health care liability claim" means a demand by any person (whether or not pursuant to an alternative dispute resolution system, an action in State court, or an action in Federal court) concerning the provision of health care goods or services, if made against a health care provider or the manufacturer, distributor, supplier, marketer, promoter or seller of a medical product, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision or use of (or the failure to provide or use) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action.

(12) HEALTH CARE PROVIDER.—The term "health care provider" means any person or entity required by State or Federal laws or regulations to be licensed, registered, or certified to provide health care goods or services or whose health care goods or services are required to be so licensed, registered, or certified, or which are exempted from such requirement by other statute or regulation.

(13) INJURY.—The term "injury" means any illness, disease, or other harm that is the subject of a health care liability claim.

(14) MALICIOUS INTENT TO INJURE.—The term "malicious intent to injure" means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(15) MEDICAL PRODUCT.—The term "medical product" means a drug (as defined in section 201(g)(1) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device as defined in section 201(h) of such Act (21 U.S.C. 321(h)), including anycomponent or raw material used therein, but excluding health care services.

(16) NON-ECONOMIC LOSS.—The term "non-economic loss" means physical impairment, emotional distress, mental anguish, disfigurement, loss of enjoyment, loss of companionship, loss of services, loss of consortium, and any other non-pecuniary losses.

(17) RECOVERY.—The term "recovery" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of a claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(18) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

(20) STATE LAW.—The term "State law" includes all constitutional provisions, statutes, laws, judicial decisions, rules, regulations, or other State action having the effect of law in any State.

SEC. 809. EFFECTIVE DATE; GENERAL PROVISIONS.

(a) IN GENERAL.—This title shall apply to any health care lawsuit brought in a Federal or State court, and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this Act, except that any health care lawsuit arising from an injury occurring before the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

(b) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this title supersede chapter 171 of title 28, United States Code, relating to tort claims procedure and, subject to section 802, preempt State law to the extent that State law differs from any provisions of law established by or under this title.

(c) PROTECTION OF STATES' RIGHTS.—Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) will be governed by otherwise applicable State or Federal law. Subject to subsection (d)(2) and section 802, this title does not preempt or supersede any law that imposes greater protections for health care providers, plans, and organizations from liability, loss, or damages that those provided by this title.

(d) RULE OF CONSTRUCTION.—No provision of this title shall be construed to preempt—

(1) the implementation of any State sponsored or private alternative dispute resolution program;

(2) pursuant to section 802, any State statutory limit (whether enacted before, on, or after the date of the enactment of this Act) on the total amount of economic, non-economic, or punitive damages that may be awarded in a health care lawsuit, whether or not such State statutory limit permits the recovery of a greater or lesser amount of such damages than is provided for under section 804; or

(3) any defense available to a party in a health care lawsuit under any other provision of Federal law.

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